



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

PINE CREEK MEDICAL CENTER

**Respondent Name**

OLD REPUBLIC INSURANCE COMPANY

**MFDR Tracking Number**

M4-16-0789-01

**Carrier's Austin Representative**

Box Number 44

**MFDR Date Received**

November 19, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "there is a 2015 Clinical Diagnostic Laboratory Fee Schedule in place, and a way to bill for these charges as a facility setting. . . . Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X claim . . ."

**Amount in Dispute:** \$70.10

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "All codes are Medicare status indicator N. . . . The CMS description is that stats N codes are never separately payable."

**Response Submitted by:** Gallagher Bassett

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2015	Outpatient Hospital Services	\$70.10	\$52.10

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - This is a packaged item. Services or procedures included in the APC rate, but NOT paid separately. (MNSR)
  - Recommendation of payment is based on a procedure code that best describes the services rendered (Z652)
  - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. (ZD86)
  - W3 – Request for reconsideration (ZE10)

## Issues

1. Are the disputed clinical laboratory services separately payable?
2. What is the recommended payment amount for the services in dispute?

## Findings

1. This dispute is regarding outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

28 Texas Administrative Code §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in the rule.

28 Texas Administrative Code §134.403(b)(3) defines "Medicare payment policy" as reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

The insurance carrier denied disputed services with claim adjustment explanation "This is a packaged item. Services or procedures included in the APC rate, but NOT paid separately. (MNSR)"

The requestor argues, "there is a 2015 Clinical Diagnostic Laboratory Fee Schedule in place, and a way to bill for these charges as a facility setting. . . . Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X claim . . ."

The services in dispute are facility services involved in providing the technical component of clinical diagnostic laboratory procedures billed on form UB-04 with bill type code 0141, reserved for billing laboratory services normally bundled into the payment for other facility services, but that were provided to a patient when no other payable OPPS procedures were performed on the same date. In these circumstances, laboratory services are not bundled and are instead reimbursed in accordance with Medicare's Clinical Laboratory Fee Schedule.

Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 16 - Laboratory Services, §30.3 – "Method of Payment for Clinical Laboratory Tests - Place of Service Variation":

**Non-Patient (Referred) Laboratory Specimen** - A non-patient is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital. All hospitals . . . bill non-patient lab tests on TOB 14X. They are paid under the clinical laboratory fee schedule at the lesser of the actual charge, the fee schedule amount, or the NLA [A national limitation amount for the HCPCS code as provided by §1834(h) of the Act.]

Review of the submitted documentation finds that the disputed services are supported as billed. According to Medicare payment policies effective on the date of service, these services are separately payable under Medicare's Clinical Laboratory Fee Schedule. The insurance carrier's denial reasons are not supported. The services will therefore be reviewed for payment according to applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.403(h) states:

For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

28 Texas Administrative Code §134.203(e)(1) provides that the MAR for pathology and laboratory services shall be "125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service."

Reimbursement for the disputed services is calculated as follows:

- For procedure code 36415, service date July 15, 2015, the fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75.
- For procedure code 80048, service date July 15, 2015, the fee listed for this code in the Medicare Clinical Fee Schedule is \$11.51. 125% of this amount is \$14.39.
- For procedure code 81003, service date July 15, 2015, the fee listed for this code in the Medicare Clinical Fee Schedule is \$3.06. 125% of this amount is \$3.83.
- For procedure code 85025, service date July 15, 2015, the fee listed for this code in the Medicare Clinical Fee Schedule is \$10.58. 125% of this amount is \$13.23.
- For procedure code 85610, service date July 15, 2015, the fee listed for this code in the Medicare Clinical Fee Schedule is \$5.35. 125% of this amount is \$6.69.
- For procedure code 85730, service date July 15, 2015, the fee listed for this code in the Medicare Clinical Fee Schedule is \$8.17. 125% of this amount is \$10.21.

The total recommended payment for the services in dispute is \$52.10.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$52.10.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$52.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	Grayson Richardson	December 18, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**